STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155199	A. BUILDING -- B. WING	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE PARK VILLAGE	776 N UNION ST WESTFIELD, IN 46074

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/31/23 Facility Number: 000106 Provider Number: 155199 AIM Number: 100266390 At this Emergency Preparedness survey, Maple Park Village was found to be in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 106 certified beds. At the time of the survey, the census was 80. Quality Review completed on 11/03/23	E 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 11/16/23.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/31/23 Facility Number: 000106 Provider Number: 155199 AIM Number: 100266390 At this Life Safety Code survey, Maple Park Village was found not in compliance with	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 11/16/23.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anthony Link	Executive Director	11/15/2023

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 106 and had a census of 80 at the time of this survey. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except for three detached sheds used for facility storage. Quality Review completed on 11/03/23			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 25 portable fire extinguishers in the facility were installed and kept in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 1-6.3 states Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of a fire. Preferable they shall be located along normal	K 0355	K 355 Fire Extinguishers **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** The Hoyer lift was moved away from the fire extinguisher. None of the 24 residents, 4 staff, and 2 visitors	11/16/2023

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	paths of travel, including exits from areas. This deficient practice could affect as many as 24 residents, 4 staff and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Administrator, on 10/31/23 at 1:16 p.m. the ABC portable fire extinguisher located in the corridor between resident rooms #209 and #211 was obstructed by Hoyer lift. Based on interview at the time of observation, the Administrator acknowledged the fire extinguisher located in the corridor, was obstructed by the Hoyer lift, and not readily accessible for use in case of a fire situation. This item was again discussed at the exit conference on 10/31/23 at 2:20 p.m. 3.1-19(b)		showed injury due to the alleged deficient practice. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Any instances of fire extinguishers being obstructed will be addressed immediately. All staff were inserviced and educated on ensuring fire extinguishers are un obstructed. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** Staff were inserviced and educated on ensuring fire extinguishers are un obstructed. Maintenance supervisor will conduct rounds daily to ensure fire extinguishers are un obstructed. **1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Facility will used K 355 CQI audit tool. Observations will be 5 times per week for 4 weeks, and then weekly for 5	

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			months. If 90% compliance is not achieved, an action plan will be developed. After six months the QAPI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. 5. **Date of Compliance 11/16/2023**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of			

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	unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 56 sets of resident room doors to the corridor would close completely and latch into the door frame. This deficient practice could affect as many as 24 residents, 4 staff, and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Administrator, on 10/31/23 at 1:26 p.m., the corridor door to resident room # 214 failed to close and latch into the frame. Based on interview at the time of observations, the Administrator acknowledged the aforementioned resident room door as failing to fully close and latch into the door frame adding that he would have the Maintenance Director make adjustments to the door as soon as he returned to work. This item was again discussed at the exit conference on 10/31/23 at 2:20 p.m.	K 0363	K363 Corridor- Doors **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** The door latch and striker plate were adjusted to ensure the door latched properly into the frame . None of the 24 residents, 4 staff, and 2 visitors showed injury due to the alleged deficient practice. **2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Any instances of resident room doors to the corridor that don't close completely and latch into the frame will be addressed	11/16/2023

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	3.1-19(b)		immediately. All staff were inserviced and educated on ensuring that any instances of resident room doors to the corridor that don't close completely and latch into the frame will be reported to maintenance personnel or administration immediately. **3.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** All staff were inserviced and educated on ensuring that any instances of resident room doors to the corridor that don't close completely and latch into the frame will be reported to maintenance personal or administration immediately. Maintenance supervisor will conduct audits weekly then monthly to ensure that all resident room doors to the corridor close completely and latch into the frame . **4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Facility will used K 363 CQI audit tool. An audit of all resident room doors to the corridor will be weekly for 4 weeks, and then monthly for 5 months. If 90% compliance is not achieved, an	

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			action plan will be developed. After six months the QAPI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. **5.Date of Compliance 11/16/2023**	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover			

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	devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff was maintained in accordance with 19.7.4. LSC 19.7.4 requires ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. Metal containers with a self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas were smoking is permitted. This deficient practice could affect staff only as residents are not allowed to smoke in or outside of the facility. Findings include: Based on observations made during a tour of the facility with the Administrator, on 10/31/23 at 1:04 p.m., there were approximately 30 cigarette butts mixed in with dry leaves immediately adjacent to the smoking area. Based on interview at the time of observation, the Administrator acknowledged the cigarette butts mixed in with the dry leaves immediately adjacent to and around the smoking area adding that he would have them taken care of as soon as he could. This item was again discussed at the exit conference on 10/31/23 at 2:20 p.m. 3.1-19(b)	K 0741	K741- Smoking Regulations **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** This deficient practice could affect staff only as residents are not allowed to smoke in or outside of the facility. The cigarette butts and leaves were swept up in the area. **2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents have the potential to be affected by the alleged deficient practice. All staff were inserviced and educated on ensuring that cigarette butts are disposed of in an approved metal ashtray. **3.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** All staff were inserviced and educated on ensuring that cigarette butts are disposed of in an approved metal ashtray. Housekeeping supervisor will conduct daily audits 5 times per week and then weekly to	11/16/2023

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			ensure that cigarette butts are disposed of in an approved metal ashtrays. **4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Facility will used K 741 CQI audit tool. An audit tool to ensure that cigarette butts are disposed of in an approved metal ashtrays will be used 5 times per week for 4 weeks, and then weekly for 5 months. If 90% compliance is not achieved, an action plan will be developed. After six months the QAPI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. **5.Date of Compliance 11/16/2023**	
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			

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	Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 7 corridors. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect as many as 24 residents, 4 staff and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Administrator, on 10/31/23 at 1:10 p.m., the electrical panel in the corridor between resident rooms #204 and #206 was completely obstructed from access by a Hoyer lift being stored in the corridor. Based on interview at the time of the observations, the Administrator acknowledged the Hoyer lift was stored immediately in front of the working space in front of electrical panel between resident rooms #204 and #206. This item was again discussed at the exit conference on 10/31/23 at 2:20 p.m. 3.1-19(b)	K 0911	K911- Electrical Systems- Other **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** The Hoyer Lift was moved away from the electrical panel. None of the 24 residents, 4 staff, and 2 visitors showed injury due to the alleged deficient practice. **2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Any instances of electrical panels being obstructed will be addressed immediately. All staff were inserviced and educated on ensuring electrical panels are un obstructed. **3.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** Staff were inserviced and educated on ensuring electrical panels are un obstructed. Maintenance supervisor will conduct rounds daily to ensure electrical panels are un obstructed.	11/16/2023

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			4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Facility will used K 911 CQI audit tool. Observations will be 5 times per week for 4 weeks, and then weekly for 5 months. If 90% compliance is not achieved, an action plan will be developed. After six months the QAPI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. **5.Date of Compliance 11/16/2023**	